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LECTURES.

GASTRIC VERTIGO.¹

A CLINICAL LECTURE DELIVERED AT THE PENNSYLVANIA HOSPITAL, PHILADELPHIA.

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GENTLEMEN, — This woman was admitted to the wards on the 18th of March of this year. She is forty-six years of age, a widow, and has evidently been in the habit of taking good care of herself. Her family history is excellent. The patient states that she has often had eruptions on her skin, but we cannot account for their appearance by the existence of any specific cause. She has also had rheumatism occasionally, with pain over the region of the heart and palpitation. She is now suffering slightly from some uterine disease, probably endometritis; her menses ceased some time since. Two months ago, that is, just prior to her admission, she had a very severe attack of giddiness, during the course of which she vomited greenish matters and complained of intense pain in her stomach, back, and eyes. When admitted, she suffered principally from vomiting, sick stomach, vertigo, and general debility. Over the epigastric region there was some tenderness upon pressure. Auscultation of her heart revealed the presence of a slight basic murmur. Her temperature was 98°, pulse 80, and respirations 20 to the minute. The urine was carefully examined, but contained no albumen and no sugar, and was of low specific gravity. The woman was at once put to bed.

Every attempt to get out of bed produced the most intense giddiness. In fact, during the early weeks of her sickness the patient was giddy most of the time, both day and night, but particularly in the day-time. She was frequently aroused from sleep at night by attacks of vertigo. This was most marked when the patient assumed the erect posture, and troubled her least when she was lying down, although even then she was not by any means free from it. This symptom of her disease was,

¹ Reported for the JOURNAL.

in fact, so exaggerated that at times she could not walk at all, and would stagger and fall when she got out of bed and made the trial. Whenever she attempted to read anything she became dizzy and confused. Her dizziness was essentially an objective vertigo. The bed upon which she slept, and in fact all outside objects, seemed to be constantly swaying to and fro. Her own body never appeared to move. As the case progressed the nausea and vomiting became very troublesome, and she suffered greatly from protracted attacks of morning headache. Her gait grew unsteady and very irregular, and when she tried to walk she always expressed a great dread of falling to the ground. I had her eyes carefully examined with the ophthalmoscope, but no chinking of the discs was found.

Under the treatment, which I shall mention to you later in the hour, the patient has grown very much better, so that she is able to walk about with considerable ease. Her color, too, has greatly improved, and her tongue looks much cleaner. The gastric symptoms have almost entirely disappeared. She is still occasionally giddy, however, particularly when she moves or gets out of her bed suddenly. The heart murmur has altogether disappeared.

Having thus made the history of the case complete as far as possible up to the present date, it remains for me to explain to you the cause of all the symptoms. What was the matter with the patient? It was very difficult to determine the question; there were, indeed, two distinct explanations which might be given. I might have thought it a case of severe brain disease with gastric disturbance; or, reversing this view, I might have concluded that the root of the whole difficulty lay in the state of the stomach. Which view should I select — brain disease or gastric disease? The proper treatment for the first would be injurious treatment for the second. On weighing the evidence, I made up my mind that the case was one of gastric vertigo. Let me give you my reasons. The prominent symptoms of the case were nausea, vomiting, and coated tongue; in cases of gastric disturbance due to brain disease the tongue is but little coated. Again, the woman had frequently complained of painful digestion; now, this symptom plainly indicated a gastric lesion, being but rarely found in cases of brain disease.

Was there anything about the character of the vertiginous sensations by means of which it was possible to determine the site of the lesion? Yes, there were several peculiarities. In the first place the patient had told us that she was better when her head was low; gastric vertigo is nearly always relieved upon assuming the recumbent position. This is an excellent point of diagnosis. Furthermore, I have told you that the vertigo in this case was of the objective sort; gastric vertigo is usually objective vertigo. Another common symptom of gastric vertigo is that the sufferer from this complaint frequently wakes up at night with ver-

tiginous sensations ; this is not often the case in cerebral disease. Moreover, vertigo linked to a brain affection is more or less persistent, whereas vertigo from gastric disease is very rarely continuous, generally occurring in seizures. . . .

During the week which has elapsed since you last saw this woman her symptoms have not practically changed. For the past few days she has been a little more distressed than usual, owing to an acute attack of gastric disturbance. But this morning she tells me that her vertigo is almost entirely absent.

We had determined when I last saw you that the present case was clearly one of gastric vertigo, for the following reasons: The vertigo was and is objective. It is, as a rule, relieved when the recumbent position is assumed, and is always worse when the patient is in the erect position. A coated tongue is but rarely or never present in cases dependent upon cerebral disease. Digestion is painful in cases of gastric vertigo. The vertigo is often present at night.

Another fact peculiar to cases of this disease is that when the patient is walking about and is surprised by an attack, if he but seize any object, however insignificant, the vertigo will be temporarily arrested. One of my patients is in the habit of carrying a walking-cane with him wherever he goes, and if an attack comes on he simply puts the end of his cane to the ground, and so steadies himself. This procedure would not have much, if any, effect in vertigo from organic disease of the brain. Let me then impress upon you the fact that in cases of gastric vertigo the least support may cut short the attack or temporarily postpone it.

Another peculiarity of gastric vertigo, which is not present in this woman, is that the attacks very frequently assume the form of violent paroxysms, the patient being entirely free from discomfort between times. I know of one instance, in particular, where the attacks come on only every six months, and last but a day or two. They in that case, however, are not brought on by any debauch or intemperance. I can call to mind still another example, where the patient suffers from the disease only while he is traveling.

Before dropping the discussion of the symptomatology of the disease I wish to speak to you of the curious dread which professional men with gastric vertigo very generally have. I have had physicians from a distance frequently come to see me when troubled with this strange malady, and the first question which they have asked me has been, "Am I going to be an epileptic?" In very many instances it has been difficult to make them believe that their symptoms were of purely gastric origin, and that they could in time almost certainly be cured ; to men who by daily experience know the character of the initial vertigo of epileptics, their own symptoms seemed only too much of the same nature.

I can say to you quite positively that the prognosis in cases of true gastric vertigo is favorable. The recovery may not take place for weeks, or perhaps for months, but still it is ultimately effected. Very often in bringing about a cure it may be necessary for the patient to make an entire change in his habits and surroundings, — to take a sea voyage, or a trip of some duration.

Concerning the various points of diagnosis, I think I have already dwelt sufficiently upon them. The absence of persistent headache, of motor palsy, and of sensory disturbance is always a strong point in favor of the gastric origin of the disease. The ophthalmoscope, too, up to a certain point, will help us. If an examination of the eye with this instrument showed incipient choking of the discs or marked retinal hyperæmia, it would be an excellent proof that the disease was of cerebral origin. In cases of gastric vertigo the eye-ground looks perfectly natural, indicating only perhaps a state of slight cerebral anæmia or of venous turgescence. It would not do, however, to conclude that because the eye-ground was healthy the vertigo was, beyond all doubt, gastric in its nature. The fact could only be used as a presumption in favor of that view of the case. Understand me, therefore, as saying that I do not lay too much stress upon ophthalmoscopic revelations as diagnostic indications in this affection.

The cause of this disease, that is of the vertigo, is very hard to determine. It is probably due to a disordered condition of the blood-vessels, that is, either permanent or temporary contraction or distention. Eminent authorities have defined gastric vertigo as a sympathetic disturbance of the vessels of the brain, due to some extent to the influence of the vaso-motor system.

Dr. Woakes, in the last number of the *American Journal of the Medical Sciences* (April, 1878), has traced the path of a filament of the pneumogastric nerve on its way to join the lower cervical ganglion and from the point of junction to the labyrinth of the ear through the inhibitory nerves furnished to the vertebral artery from the ganglion. A distinct anatomical connection is thus made out between the stomach and the brain. The writer then goes on to say that stomach vertigo is evidently due to vaso-motor influence, and likens it to Menière's disease of the semicircular canal, where vertigo is also a very prominent symptom. This is certainly a plausible explanation of the facts of the case.

In speaking to you of the treatment of this disease I shall fall back chiefly upon my own experience in the matter, which has been large, for within the last four or five years I have had a considerable number of such cases under my care in hospital and private practice. To sum up the results of my experience, I may say to you that on the whole I think the best treatment consists, after regulating the diet, in the administration of bitter tonics and alkalies. Particularly was this true in

the case of the gentleman, already referred to, who was in the habit of aborting his attacks by steadying himself with a cane. That patient was always immediately benefited by the use of Vichy and Karlsbad waters and the bicarbonate of sodium. These alkaline waters should of course be taken after meals. At the same time the general tone of the stomach should be invigorated by bitters before meals. Later on in the course of the disease I prefer the use of iron combined with one thirtieth of a grain of strychnia thrice daily. The way to the employment of these remedies must be paved, however, by the regular administration of bitters and of alkaline waters.

Another plan of treatment which I have employed consists in the administration of small doses of corrosive sublimate, while paying strict attention to the bowels and diet. I have found corrosive sublimate to exert a most happy influence upon the gastric and cerebral phenomena.

In a certain way I have followed the first-mentioned plan of treatment in the present case. I have given gentian and then iron, in the shape mainly of the dialyzed preparation, both internally and by hypodermic injection since the gastric symptoms began to improve. You understand that I consider iron to be a good remedy late in the course of the disease, when the stomach is improving its condition, but not early in the case, when it is not always well digested, and when the constipation it may induce is especially to be avoided.

A word to you before closing as regards the hypodermic injection of dialyzed iron. As you already know, I have used that form of administration in a case of chlorosis, where the stomach was not very retentive, with the most excellent results. I ordered in that instance at first an injection of fifteen minims daily of pure dialyzed iron diluted. Afterwards, finding that the girl showed no bad effects from such a use of the drug, I had the dose increased to twenty, twenty-five, and finally thirty minims of undiluted iron daily. The punctures marking the spots where the needle was introduced exhibited no signs whatsoever of inflammatory action. The improvement was most marked. The girl's menses came on regularly, her digestion improved rapidly, her strength increased daily, the color returned to her lips, gums, and tongue, and the "venous hum" which was at first loud and marked, grew faint and distant.¹

Since then I have used the dialyzed iron in other instances. I tell you candidly that the subsequent results have not been as favorable. The constitutional effects have been good, but the local effects unsatisfactory, as, in truth, they were in the patient whose case I have been discussing with you. Lately the injections have caused a great deal of local irritation. I have found that of two bottles of dialyzed iron, even be they both from the same maker and purchased at the same time, the

¹ See JOURNAL, March 21, 1878.

contents of one bottle will irritate and those of the other will not. The reason of this evidently is that all bottles of the preparation are not entirely neutral. Nay, from the same bottle I have had the most excellent effects for a few days in the use of the iron, and then after that time the drug began to irritate, which shows that even of the same bottle one half may be bland and the other become irritating.

Notwithstanding all this I have not given up using iron hypodermically in appropriate cases. I have lately been experimenting with some other forms, among them the ammonio-citrate of iron, which I have found to be reliable. This is, however, only a provisional statement, and is thrown out as an anticipation of what I hope to be able to prove definitely by experiment. I will say positively that thus far its effects have been most excellent. In a number of cases in the wards of this hospital I have injected from two and a half to five grains of the ammonio-citrate in fifteen minims of distilled water without any bad effect whatsoever, either locally or otherwise. In the wards of my colleague, Dr. Hutchinson, the needle has been passed deeply into a patient's tissues six or seven times without any local irritation. There is an instantaneous nausea produced in some cases following the injection, but as the same nausea follows the use of plain water it certainly must be largely the result of imagination.

WHAT IS THE OBJECT OF THE MASSACHUSETTS MEDICAL SOCIETY, AND HOW CAN IT BEST BE FULFILLED?¹

BY ROBERT T. EDES, M. D.

It is customary, in the preludes to codes of ethics and in annual addresses, to set forth in rather high-flown language the duties and qualifications of the medical practitioner, tending to convey to the uninitiated the impression that the profession is or ought to be composed chiefly of sages, saints, and martyrs; but it seems to me more appropriate and more practical, instead of starting forth with certain preconceived notions as to an impossible ideal, to consider what the state of the profession really is, and what a medical society can do for it.

At present there is in this enlightened and progressive State no sort of official definition of what a physician is. Various papers are required to be signed by "a physician" or by "a respectable physician," but I do not know of any person, claiming to be a physician, who is not allowed to sign such papers, and whose signature is not valid thereon. Boards of health and insurance companies look a little more closely into some men's certificates than others, and the indubitable quack and ignoramus may be pushed a little harder on the witness stand than a

¹ Read before the Dorchester Medical Club, May 16, 1878.

well-known and respected practitioner; but there is no tribunal which has a right to say authoritatively to any man, "You are not a physician in the eye of the law," or, "You are not a respectable physician."

The law does not give to our title of M. D. even the protection afforded to the two-cent stamp on a bottle of soothing syrup, for its assumption cannot be punished; and the practitioner whose degree testifies to at least a minimum of three years' study and examination, and who may have added thereto many more years of foreign study and domestic experience, has no remedy if the man who to-day blacks his boots or puts in his coal appear to-morrow in the opposite house, having his name, followed by M. D. and as many more letters as he pleases, inscribed thereon in gold.

This is intended as a statement of facts, and not as a complaint. Perhaps it is best so. This is a free country, and the dearest privilege of the American citizen is to humbug and to be humbugged; but such a condition of things imposes duties upon a medical society which it need not assume in less "progressive" regions. Yet we may find here gentlemen who have received as elaborate and thorough an education as the expenditure of time, labor, and money can give, and others who with fewer advantages deservedly occupy, both for their eminent scientific and practical ability and their high moral character, positions of the greatest responsibility, and justly receive the respect of the communities in which they live. From these down, however, there is a constantly descending scale to the lowest quack. No one can tell exactly where the line runs that separates the physician from the quack. Many are undoubtedly above, many undoubtedly below, but many also so near the line that their position is doubtful.

The most important and most practical function of the Massachusetts Medical Society, as it seems to me, is to draw this line, and in every way possible, by the strictness of its requirements within reasonable and attainable limits, by the encouragement of scientific work and the discouragement of all dishonesty and unfairness, to make it as distinct as possible; that the physician may be separated from the quack by so wide an interval that nobody can possibly mistake one for the other. The line *must* be a somewhat arbitrary one, and the society takes upon itself the burden of a sort of registration of persons with suitable attainments to become members, furnishing so far as a society can a sort of guarantee of character, both professional and moral. The more thoroughly this duty is performed, the more useful and influential the society will become.

Other professions have organized similar societies which confer no legal privileges, but which do give a sort of guarantee of respectability. The best guardians of the highest interests of a profession are to be found within itself; and although we might rightfully ask the law to

give some protection to the physician as against the quack, that protection would be most efficiently afforded simply by protecting a degree or title which might be granted by the Massachusetts Medical Society or its delegates.

To perform this function properly the society should, as indeed it now does through its boards of censors, fix a minimum of attainments to be demanded for membership, regulating its demands by the existing condition of medical education, and by the amount of professional information expected of practitioners in good standing, rather than set up an impossible ideal. The individual member may seek for perfection in knowledge and character, but the stimulus must come from within and not from without.

He may say what he will strive to become. The society has a right to say only what the applicant *must* already have become before he can be received as a member. In order, however, that the line of demarcation should be a distinct one, in order that membership should be a criterion of value in the eyes of the profession and the public, fitness therefor should consist solely in competence and honesty of purpose. If membership is to be honor and non-membership disgrace, let no one be able to say that exclusion from the Massachusetts Medical Society is a mere matter of prejudice, of dislike, or of theoretical notions as to the fitness of this or that class to practice medicine.

The barrier must not only exclude the unworthy, but also include all the worthy. The society needs upon its side, as an organized foe to quackery, all honest and intelligent persons, and cannot afford to place them, even apparently, in opposition to it by excluding them from its privileges and classing them among the quacks outside of its artificial limits.

Thus far the society has persisted in the exclusion of a class — not large, perhaps, but important — of intelligent and competent persons, and this on the entirely irrelevant ground of sex.

I think we have here but little to do with theoretical notions as to the ability of women to practice medicine. Certain drawbacks they undoubtedly have, and I may entertain my own private opinion of the probability of many women becoming distinguished physicians; but we can practically ask of them, as we ask of men, only a minimum of attainment, and their physical disabilities are nobody's business but their own.

Whether or not I should want my daughter to become a physician is as pertinent to the question before us as the somewhat similar inquiry that used to be asked in *ante bellum* days, "Should you want your daughter to marry a negro?" It will be time enough to answer it when it really arises; but if she should become a doctor I should want her to be a respectable one, and not be obliged to fraternize with quacks against her will.

We are, however, in presence of a fact. The female practitioners are here and at work. Some of them (and we ought to thank them for the compliment) desire to join the Massachusetts Medical Society. They look upon its membership just as we wish it to be looked upon, as a guarantee of respectability. We have no right to impute to them other than worthy motives, the same motives which make *us* unwilling to be mingled in an indiscriminate mass of good, bad, and indifferent. We can hardly suppose that they care a great deal about obtaining their "Braithewaite's" at a reduced figure, or are seized with an insane longing for the publications of the society, or even for the annual dinner, delicious though it be. Money can have but little or nothing to do with it. I see no reason why membership in the Massachusetts Medical Society should increase their yearly incomes by a dollar.

Why should not the best of the female practitioners have exactly the same reasonable desire not to be confounded with the quacks of their own sex (who undoubtedly exist) that we have? And why should they not, being comparatively few in number, ask of the Massachusetts Medical Society to give them recognition for this purpose? Both justice and wisdom demand the granting of the wish.

Their numbers and influence would, so far as they go, be of value to us, but the presence of even a single well-qualified woman would serve to relieve the society of the reproach of prejudice and bigotry which, I cannot help thinking, sometimes rests upon it. If we are told that the society in expelling the homœopaths showed itself intolerant, narrow-minded, and non-receptive of new ideas, we wish to be able to reply: "Not so. We believe the homœopaths to be unscientific, illiberal, and many of them dishonest. We ask, for membership, only competent knowledge, liberal principles, and freedom from artifice. We are not influenced by prejudice. Every suitable person is welcome."

But if the objector continue, "Why then do you exclude women as a class?" we cannot say, "Because they are illiberal or incompetent," for they profess to practice upon the same principles as ourselves; they have been perhaps educated by the same teachers, and have read the same books.

Women in other States are admitted to societies, and their remarks are listened to with respectful attention; their essays carry off our Boylston prizes, and receive high praise abroad. As to their competent knowledge, all they ask of us is to put them to the same test with other candidates, and allow them to demonstrate it.

As to moral qualifications no test has yet been devised except the observation of daily life and works, — a test which, I think, has as yet revealed no conspicuous failure of women as a class.

So long as a single intelligent, well-educated, and honest person seeks admission to the Massachusetts Medical Society, and is denied, so long

the society fails to fulfill its most important function of discriminating between the respectable practitioner and his counterfeit, and for so long it cannot be established on its only possible solid foundation, on which alone it can command universal respect, absolute and impartial justice.¹

RECENT PROGRESS IN DENTISTRY.

BY THOMAS H. CHANDLER, D. M. D.

THE latest excitement in the dental world has been caused by the advocates of the so-called *new departure* at a late meeting of the Odontological Society of New York. As stated by them through Dr. J. Foster Flagg, of Philadelphia, this new departure is as follows:—

NEW DEPARTURE CREED.

I. In proportion as teeth *need* saving, gold is the *worst* material to use. II. Neither "contouring filling" nor "separating teeth" has much to do with the arrest of decay. III. Failure in operations is mainly due to incompatibility of filling material with tooth-bone. IV. A tooth that can be so treated as to be filled satisfactorily with *anything* is worth filling. V. Skillful and scrupulous dentists fill with tin covered with gold, *thereby* preventing decay, pulpitis, death of the pulp, and abscess, and *thereby saving the tooth*. VI. A filling may be the *best known* for the tooth, and yet *leak badly*. VII. Gutta-percha, *properly used*, is the *most permanent* filling material we possess. VIII. A *poor* gutta-percha filling, *in its proper place*, is better than a *good* gold one. IX. Amalgam, *per se*, is an *excellent* filling material. X. The use of "plastic" filling material tends to lower that dentistry which has for its standard of excellence "ability to make gold fillings," but very much extends the sphere of usefulness of that dentistry which has for its standard of excellence "ability to save teeth."

The third article contains the *raison d'être* of the whole matter, namely, the incompatibility of fillings with tooth substance. The idea has for some years been gaining ground that the failure of the work of even the best operators must be caused by some mysterious agency aside from bad work, for it could not be that, and electrical action was suggested. The word electricity is a word of power, like that on Solomon's seal, and at once accounted for whatever was unknown, if not for the unknowable. Some experimenters in England first took up the investigation to ascertain what, if any, was the action of this agent, and some remarkable results were claimed. An essay was read before the Odontological Society of Great Britain; this was published, and there for a while the inquiry paused. Shortly after, Dr. S. B. Palmer, of Syracuse, again took up the subject in earnest, and has devoted his

leisure for several years to experimentation. He asserts that the tooth substance makes with any other substance a galvanic battery, and, being easily acted on by acidulous fluids, it becomes with most filling materials the positive pole, and therefore the one to be destroyed. Of all the materials used by dentists in their attempts to preserve the human teeth he claims that gold is, in the electro-chemical scale, the worst; then come the amalgams, though with a wide interval; then tin; then gutta-percha; and last the oxy-chloride of zinc. Between the last two stands dentine or tooth-bone; therefore the oxy-chloride, were it not for its easy destructibility, would make the only perfect filling, and next to this are the compounds of gutta-percha. All others are more or less dangerous in proportion as the tooth itself is of good or poor material, and the fluids in the mouth acid, alkaline, or neutral. The advocates of this new doctrine are Palmer of Syracuse, Chase of St. Louis, and Flagg of Philadelphia, who is their mouth-piece. As usual with new doctrines all its disciples do not take precisely the same ground, though all despise gold and love amalgam and gutta-percha. The somewhat startling assertion is made that gutta-percha, though it cannot be made water-tight, but is always leaky and always admits the acid saliva to direct contact with the tooth-bone, is yet better than the best gold filling, which is the same as saying that the mere presence of the gutta-percha in a carious tooth is preservative. If this is so, why fill both of two contiguous cavities, and not trust the gutta-percha in one to save the other?

There can be no doubt that this shell thrown into the dental lines will for a long time affect the practice. Many who have heretofore avoided amalgam as the unclean thing, and used other plastic materials only as temporary work, will now be tempted to experiment with them; many who have used them sparingly, believing and acting on Article IV., will venture still further, and adopt them for ordinary cavities not offensively conspicuous; while the quack and the charlatan, who have always employed them freely, supported by the prestige of such names, will throw aside what little reticence they may have had, and openly proclaim themselves disciples and leaders of the new departure. This is not the place to argue the matter, but doubtless it is a long step backward, as destructive of all pride of appearance in the patient, and pride of work in the practitioner, removing all incentive for care and skill aside from the stimulus of his conscience.

In another direction has been the work of Dr. G. F. Waters, whose experiments upon his own person with scalding water and bicarbonate of soda are somewhat notorious. He claims in several cases that have come under his care to have restored not only the bone lost by necrosis, where the periosteum has been uninjured, but the destroyed periosteum itself. In a paper read before the Massachusetts Dental Society at the December meeting he narrated several instances where this had been

done successfully, the patient restored to comfort, and the diseased parts to usefulness. His method consists chiefly in the injection of aromatic sulphuric acid, of varying strength, into the diseased tissues, with the idea of dissolving out necrosed bone and stimulating the parts so that nature may act. This plan of removing necrosed bone is not new. In one of the old numbers of the *JOURNAL* is an account of a case where this was done by Dr. D. M. Parker, of this city; it has been employed in England for diseased tibiae, and has been persistently advocated by Dr. Wm. H. Atkinson, a dentist of New York, who claims that it has no injurious effect on living tissue, but dissolves out dead bone with certainty. It is believed, however, that no one has attempted to restore the periosteum, or claimed to have done so even accidentally. Besides the cases mentioned in his paper, Dr. Waters illustrated his remarks by instances drawn from the work of nature in restoring lost tissue in birds and animals.

In the matter of dental education a real and valuable new departure has just taken place, namely, the establishment in connection with the medical department of the University of Pennsylvania of a dental school, with an endowment and means furnished for the proper prosecution of the work without an absolute dependence upon the fees derived from its students. It is thus placed at once upon a firm footing, born, like Minerva, fully armed, through the liberality mainly of the trustees. A building is erecting at a cost of fifty-five thousand dollars, whose first floor is for the clinics of this school, one hundred and forty feet by forty, affording ample room and light for the most delicate operations, and full accommodations for all other necessities of a well-organized dental school, "unequaled in America." The second floor is for the chemical laboratory for both medical and dental students. The trustees say in their announcement, speaking of dentistry, "Now, so many new methods and theories are embraced in its successful practice that nothing but the broadest and most thorough training in the collateral sciences will enable its members to practice it intelligently and successfully. These are facts recognized and admitted by many members of the dental profession, some of whom have occupied positions as teachers, and who have been forced to the conclusion that competent instructors, laboratory conveniences for practical instruction in chemistry and physiology, materials and accommodations for the study of anatomy, histology, and pathology, with all the numerous accessories for treating these subjects broadly and thoroughly, could be offered only by such an institution as the University of Pennsylvania, with its superabundance of these important requirements."

Prizes of instruments, medals, and money, to the number of seven, are also offered for excellence in the various departments, and the medical department holds out the further inducement that "graduates of colleges of pharmacy and dental colleges in good standing are admitted

to the *second* course in the University without an examination ;" and also "*those desiring to graduate in medicine may do so by attending a third course, . . . giving notice of such intention at the beginning of the second dental course.*"

The regular or winter session is a five months' course, and that which students are *required* to attend. This is supplemented by a spring course from the first Monday of April till the middle of June, and a fall session of two weeks previous to the beginning of the winter course, free of charge to all who attend this last. Students who attend these courses are not required to secure a preceptor for private instruction during the recesses. Attendance upon *two* full winter courses only are required for graduation, and two years' study either under a preceptor or in the spring school.

All the arrangements have been made with unprecedented liberality, and it is the only dental school in existence that has an endowment. Its success is certain from the start, as it is enough in advance of all the schools except the Harvard to attract those who are really seeking for an education, and not merely working for a diploma as an advertisement. Its position in the midst of the hospitals and colleges of Philadelphia is unsurpassed. There can be no doubt that this will give a stimulus to the cause of dental education, and spur those institutions whose pecuniary interests have hitherto stood in the way of any advance to struggle to come well up abreast. Indeed, this has already occurred. Its degree is D. D. S., doctor of dental surgery.

Another type of dental school has been lately inaugurated in the West as far in the rear as this is in the van, namely, the Western College of Dental Surgeons, which offers to examine candidates for a degree without requiring of them any previous attendance upon lectures, such evidence as they can present at an oral examination being deemed sufficient to admit them within the charmed circle of doctors. They say, "We hold that one who by his industry and perseverance has qualified himself to pass a searching and satisfactory examination without the aid of schools is entitled to take rank in any profession equally, etc., etc. But "*Quis custodiet ipsos custodes?*" Some other evidence of the qualification of the examiners should be required than an act of incorporation by the average legislature.

Another type of dental schools is the Maryland School, in Baltimore, which relegates the conferring of its degrees to a board of regents, composed of clergymen, lawyers, merchants, or any others whom a popular reputation may have called to the front on the recommendation of the faculty. The central thought in this method is that the men who teach should not also be the ones to examine, they being supposed to be inclined to favor their students. But practically the students are examined by the instructors, and the results turned over to the board

of regents, who simply do the voting and conferring in obedience to instructions.

The Michigan School, in connection with the university of that State at Ann Arbor, is still another late type of dental school. Its course is six months, from October 1st to the end of March. It demands an admission examination in writing in the ordinary branches of an English education for all not graduates of "some respectable college, academy, or high school," as to "fitness for entering upon and appreciating the technical study of medicine." Three years of study are required for the degree, including two courses in some dental "college," of which "the last must be in this school." The Harvard School terms are of *nine* months' duration, and *three* years' study are demanded, including two years in the school, of which the first is passed with the medical students, and is identical with the first year of the medical school. An examination in the studies of this year must be passed before the student can go on to the second year. One of the three years may be passed away from the school under competent private instruction, and a student by passing the first year examinations may pass at once to the second year class.

Of the fourteen dental schools in the United States, all but these five adhere mainly to the old plan of winter terms and private pupilage in the recesses. None demand more than two years' study for a degree except the Michigan University and Harvard School, and of course their standards are as their numbers, each faculty being a law unto itself; and all except the Michigan School and that of the University of Pennsylvania depend upon the students' fees for their expenses and the salaries of their officers. Such a state of things necessarily hinders all true progress, establishing rivalries between the different schools, lowering the standard, and cheapening degrees. Weak human nature should not be subjected to such temptation; therefore some plan is to be desired by which a uniform system may be established throughout the land, and the degree, whether D. D. S. or D. M. D., made to signify as nearly as possible one and the same grade of acquisition.

This short sketch of the state of instruction in dentistry is given as an indication of its real progress as a profession. Within the past twenty years a change has been going on, at times rapidly, at others slowly, in the methods, materials, and instruments for accomplishing its ends; but the real progress has been made in the means for acquiring an education, and placing the business of dentistry on a fair footing with other professions. The great multiplication of dental schools cannot be considered as all in the forward direction, but there are those among them whose aims are high, and whose curricula, faithfully followed, can and do place their graduates on a level with at least the average graduate of other professional schools.

PROCEEDINGS OF THE MEDICAL JOURNAL ASSOCIATION
OF THE CITY OF NEW YORK.

P. BRYNBERG PORTER, M. D., RECORDING SECRETARY.

REUNION Friday, May 24, 1878; Dr. Robert F. Weir, president, in the chair. On this occasion Dr. Samuel W. Gross, of Philadelphia, read a paper on The Rational Treatment of Stricture of the Urethra, with an Exhibition of some New Instruments for Internal Urethrotomy. After a graceful introduction, the reader commenced his subject proper by saying that the object of all treatment of stricture of the urethra was to restore the part as nearly as possible to its natural state. Ordinary dilatation was found to be utterly unavailing, and therefore it had been necessary to devise some other means for accomplishing this result. It was true that by such means the condition might be palliated, but the prominent symptoms were sure to recur. He could conscientiously say that even after incision of the meatus urinarius he had never yet succeeded in making a cure by dilatation with bougies, however long the treatment might be kept up. At the present day, therefore, he never practiced dilatation unless there were some contra-indication to a more radical operation, or unless the patient were unwilling to submit to the latter. Divulsion or internal urethrotomy, or perhaps a combination of both, was the method of operating to be employed; but we should always remember that with the stricture there is almost invariably a condition of subacute urethritis, and that this is apt to give rise to spasm and other symptoms which must primarily be gotten rid of.

In operating for stricture, then, there were three principal indications, namely: First, to get both the seat of trouble and the general health of the patient into the best possible condition for operation. Second, to restore the calibre of the urethra at the point of stricture. Third, to prevent urethral fever subsequently.

It was a point of great practical importance, not only as regards the diagnosis, but also the treatment, to determine whether there were any strictures in the anterior portion of the urethra, before attempting to deal with deep-seated ones. A constriction situated in this part of the canal was very apt to give rise to spasmodic stricture in the deeper portion; so that when this was overcome, the latter disappeared spontaneously. In more than one third of sixty-seven of Dr. Gross's cases the whole trouble was located in the first inch from the meatus. It was therefore a rule of his always to cut an anterior stricture before taking steps in regard to anything further back.

Dr. Gross stated that his measurements of the normal urethra differed but slightly from those of Drs. Weir and Otis. The calibre of a stricture, he considered, could be determined more accurately and easily by Dr. Weir's urethrameter than by any other instrument with which he was acquainted. With a view of inserting a splice of new material (in the language of Dr. Gouley) at the seat of stricture, he had been in the habit of resorting both to divulsion and internal urethrotomy. Of late years, however, he had been employing the former less and less frequently; not because it was dangerous, but

because it had proved unsatisfactory in its results. In many cases which he could recall submucous bands had been left unsevered after divulsion, and indeed he not unfrequently had finally to resort to urethrotomy in cases in which he tried it. It was, nevertheless, a very useful operation in cases of emergency, such as retention of urine.

Of the two methods of inserting a splice by means of internal urethrotomy, he decidedly preferred that in which the cutting was from within outward, and he had himself devised a simple instrument for that purpose. This had a bulbous exploring extremity, and within the latter was concealed a knife, which was operated by touching a spring in the handle of the instrument. The manner of using it was to carry the bulb about half an inch beyond the stricture, and then, projecting the blade by pressing the button in the handle which controls the spring, draw it forward; at the same time making counter-pressure with the unemployed hand in the perinæum. This was called the exploring urethrotome, because, after the cutting, if any bands should remain, they could easily be detected by means of it, when the operator could again project the blade and sever them. In forty-six cases occurring in private practice, and embracing eighty-seven strictures, every patient had recovered. In but one was there any unusual hæmorrhage, and the only cases in which urethral fever had occurred were those in which an anæsthetic was employed; so that he could not but believe that the fever was to be attributed to this cause. In all his cases the greatest care had been taken to prepare the patient properly for the operation; and the practice which he had employed was essentially that of Dr. Otis.

On account of the variation of the calibre of the urethra in different individuals, there were certain disadvantages connected with this method of treatment, which was based on the average normal anatomy of the part. He had met with only two cases in which the meatus was as large, naturally, as the canal behind it, and it was therefore ordinarily necessary to divide the former. As a rule, the meatus had a circumference of only twenty-four millimetres, while the spongy portion of the urethra measured thirty-two millimetres. In the event of the stricture being situated in the bulb, it was necessary to cut the meatus still more freely. But by employing a urethral expander, which he had devised, he had found that incision of the meatus was quite unnecessary when the normal relation existed between the meatus and the rest of the canal. This instrument consisted of a number 17 bougie divided for two thirds of its length into two distinct parts, which were introduced while in apposition and afterwards could be separated by means of a button slipped up between them; the extent of the separation being regulated by means of a scale in the handle of the instrument. If the normal relation existed between the different parts of the urethra, this expander acted as a wedge, separating, as it did, in a transverse manner. It could be employed for the purpose of defining the anterior part of the stricture, and also for the purpose of divulsion when the wheel controlling the movement of the separating button was turned rapidly. His experience with the instrument was as yet somewhat limited, but thus far he had had every reason to be satisfied with it.

In conclusion, Dr. Gross summed up his opinions in five axioms, with a few extemporaneous remarks upon each point:—

(1.) The rational treatment of stricture of the urethra consists in restoring the natural expansibility and calibre of the affected part. The surgeon has to act here just as he would in any other deformity, that is, by endeavoring to restore the part as nearly as possible to its normal condition; just as his friend Dr. Sayre, in a case of talipes, would cut the tendo Achillis in order to bring the foot into its natural position.

(2.) The sensibility of the urethra is first to be obtunded, in order that it may not resent the violence to which it is necessary to subject it. Urethral fever almost always occurs in those cases in which no proper preparatory treatment had been resorted to, such as the exhibition of alkaline remedies, rest in bed, attention to the bowels, etc.

(3.) After all spasm and hyperæsthesia have been overcome, the normal calibre and expansibility of that part of the urethra in which the stricture is seated are to be restored.

(4.) This can ordinarily be satisfactorily accomplished only by means of internal urethrotomy.

(5.) The meatus need not be incised unless it is more than eight millimetres in circumference less than the spongy portion; and if this is the case, it need be extended only until this standard proportion has been reached. In one hundred and one cases Dr. Weir had found that the average normal size of the meatus was 24.9 millimetres, and of the spongy portion 32 millimetres; in one hundred cases Dr. Otis had found these measurements respectively 24.7 and 32.9 millimetres; and in eighty-three cases he himself had made them out exactly 24 and 32 millimetres respectively.

Dr. Gouley remarked that the general excellence of the paper was highly commendable, and that he indorsed many of Dr. Gross's views, but stated that there were some points to which he could not give his assent. The doctor, he said, began by entirely rejecting gradual dilatation, but he thought that in doing this he had not sufficiently taken into consideration the classification of strictures. There were first strictures of idiopathic origin, such as those depending on urethritis, and secondly those of traumatic origin, and the two varieties demanded different kinds of treatment. Then, again, the situation of the stricture made a great difference also.

In deep-seated idiopathic strictures he preferred to adhere to the old plan of gradual dilatation, which had never been abandoned by either the French or the English, and was still practiced by American surgeons. Strictures of this character which were of recent origin were certainly very amenable to this treatment, and in the older ones it should at all events be given a fair trial. If after a prolonged series of efforts in this direction, extending over a period of several weeks, a good result could not be obtained, it was then advisable to resort to the cutting operation. He was sorry to hear Dr. Gross say that he rejected gradual dilatation as a means of cure in such cases, as his own experience had been so favorable with this method. In these strictures it was not simply requisite that dilatation should be carried to a point corresponding with the fullest extent of the urethra in the vicinity of the stricture, but that it should be pushed considerably beyond this. When the Russian surgeon Dr. Wywodsoff was in this country, in 1876, he made a suggestion which was consid-

ered of great practical importance. Said he, "Do you really simply dilate the stricture in the process of so-called gradual dilatation? Do you not after a time expand the urethra to a point where the submucous fibrillæ are actually torn? This has been my idea for a long time, though I have never been able to demonstrate it positively." The truth is, if this be so, that in gradual dilatation, carried to the extent to which it should be, we are practically making a divulsion. Some of the elastic fibres may contract after it, but with proper subsequent treatment the cicatricial tissue is never reproduced to such an extent as to cause any troublesome contraction. Dr. Gouley had had cases under observation now for ten or twelve years in which no recontraction has taken place, and therefore, differing from Dr. Gross, he did believe in gradual dilatation as a means of cure. Ordinarily he paid no attention whatever to the meatus; but if it were so narrow as to interfere with the full dilatation of the urethra beyond, he incised it until it was large enough to admit of the passage of a sound of appropriate size.

In regard to divulsion proper, Dr. Gouley agreed with Dr. Gross in looking upon it as a good operation under certain circumstances. He considered it of service in indurated strictures situated in the perineal portion of the urethra, but a very bad operation in those of the spongy portion.

In the fixed portion of the urethra free dilatation, resulting in divulsion, had proved a very successful operation in his hands, as in those of a number of English surgeons; though some of the latter now seemed to be infatuated with urethrotomy, and discountenanced it. In this situation he had practiced divulsion somewhat more than three hundred times with very satisfactory results, and he wanted to denounce urethra-cutting. His plan was to begin with a filiform bougie, and then pass over it successive numbers of his tunneled sounds until he reached number 14 or 15 perhaps, when he would resort to the ordinary sounds and carry them up to any number that was desired. In case the meatus was not sufficiently large, even after proper incision, he also used the urethral expander; but he had as yet had no opportunity of trying Dr. Gross's instrument. The essential point in all his operations was to make the urethra larger at the seat of stricture than it had been before the stricture had occurred, and this was done in order to allow for a certain amount of contraction in the future. His ordinary practice was to carry on expansion until the point of stricture would be as much larger than the normal calibre of that portion of the urethra as would be represented by four or five numbers in the scale of sounds. By this method of divulsion, he said, one avoided making large rents in the tissues; for the small ones were just as efficient, and were much less liable to lead to general infiltration of urine, or other unpleasant consequences.

He could not claim originality for his mode of operating, although he had worked out the idea himself before he knew that it had been previously acted upon, in a blind sort of manner, by a Swiss surgeon named Matthias Mayor, who was greatly abused by Vidal on account of his forced catheterism. Without being aware that he was really making divulsion, this operator employed very large instruments, because he considered them more easy to introduce and less liable to cause injury than small ones.

In regard to internal urethrotomy, Dr. Gouley said that he thought it was practiced to far too great an extent at the present time, and that a great deal of harm resulted in consequence. Only that very day he had received an English journal in which there were no less than three papers advocating some form of this operation. The result of all this cutting was that the urethra was practically destroyed, becoming like a worn-out India-rubber tube. The whole of the spongy portion became blocked up with inflammatory material, and an interstitial contraction took place. He then went on to say that it was a boast of his that he performed so few urethrotomies. From the time that he first saw a case in Bellevue Hospital, in 1851, the total number of his operations of this character had amounted only to forty-three, and he would venture to say that there were several much younger men present who had done it a far larger number of times than that. He considered Dr. Gross's instrument, based as it was on that of Civiale, a very excellent one; but in view of the immense number already in the hands of the profession he was inclined to believe that every man who invented a new urethrotome ought to be treated as a criminal, although he had to confess that he himself had once been guilty of the offense. In conclusion, he remarked that his views on external urethrotomy were too well known for him to reiterate them on this occasion.

In reply to a question from Dr. Gross as to whether he thought he could restore the calibre of the urethra as well by divulsion as by internal cutting, Dr. Gouley stated that he was positive that he not only could, but that he actually had done so in a vast number of cases during the last few years. If a man who had had a stricture ten or eleven years ago so small that it would not admit a number 1 sound, and had been treated in this way, should come back now perfectly well, it would be pretty good evidence of the character and permanency of the cure; and Dr. Gouley said that this had happened to him repeatedly. The operation by divulsion has the same effect as that of internal urethrotomy, namely, that of putting in a splice of tissue to extend the calibre of the urethra at the point of stricture. Of his forty-three cases of internal urethrotomy, in thirty-three the stricture was situated anterior to the junction of the penis with the scrotum, and one death occurred among them. On the other hand, there were but two deaths in more than three hundred cases treated by dilatation and divulsion in the manner described.

Dr. Gross: Do you consider it necessary to divide the meatus urinarius when it bears a normal relation to the rest of the urethra?

Dr. Gouley: I do not think it is necessary.

Dr. Otis, being called upon by the chair, stated that he felt much gratification in finding himself so nearly in accord with the distinguished author of the paper. In regard to the incision of the meatus, however, he considered it a great mistake to adopt any such standard of relative size for the orifice as Dr. Gross had done. It was true that the average of a certain number of measurements of normal urethrae at the meatus and the spongy portion was about twenty-four and thirty-two millimetres respectively; but if a standard was to be set up from any such observations, as well might the shoemaker

set up an absolute standard for the human foot, and make everybody's shoes in accordance with it. He did not consider the size of the meatus as any kind of guide to the calibre of the other portions of any urethra; for although the urethra was a kind of hose given us by nature, it was not made expressly for the purpose of ejecting urine to a great distance. Out of the hundred cases alluded to by Dr. Gross as having been examined by him, in less than twenty was there a meatus at all corresponding with the size of the urethra. If this was the normal condition when the urethrae were normal, he thought the canal should be of the same size as the meatus. In the newborn there was no fossa navicularis, and he considered it an artificial distention. In many cases of stricture the meatus was so small that even the most conservative in their opinions on this point found it necessary to divide it.

As a consequence of contracted meatus, various reflex disturbances of grave character had been observed, not only in the bladder, but in other parts of the system, and among these were various neuralgias in the back and limbs, sometimes extending to the soles of the feet, derangements of digestion, and even paraplegia occasionally. Dr. Otis mentioned that he had formerly thought that he was the first observer to discover these facts; but that he had recently become aware that Civiale had anticipated him in this respect.¹ It was astonishing, he thought, that Sir Henry Thompson, who was a pupil of Civiale, had made no mention of the matter in his writings. It was his firm conviction that the meatus should always be divided until it was equal in calibre to the fossa navicularis; which after the ordinary amount of contraction had taken place would bring it to about the size of the rest of the canal. This cutting was necessary in gleet, because it was impossible to have a tube of this kind with a contraction at any point without some friction and irritation being thereby produced.

His plan of beginning the rational treatment of stricture was to do so by preventing it; and he thought the day would come when it would be considered criminal on the part of the surgeon to allow a man to contract a close stricture. Gonorrhœa was acknowledged by all to be the cause of stricture, and yet patients suffering from this affection were almost invariably permitted to pass from under treatment without a single word of warning as to the danger hanging over them. After a while gleet would set in, and then they would wake up suddenly some morning and find that they had retention of urine. All this was the fault of the surgeon for allowing the case to go on until such consequences resulted. If in any case we found there was a stricture present, we should at once restore the parts to their natural condition. This was to be done by operation, but he considered it a great mistake to attempt it by gradual dilatation and divulsion. The tissue to be dealt with was a contractile tissue, and it always would contract after being stretched, even though it should be distended until the calibre of the stricture were made far greater than the normal size of the part.

¹ After the discussion was concluded, Dr. Gouley pointed out the fact that in his work he distinctly showed that the attention of the profession was especially called to such manifestations as these, as symptomatic of stricture, by Mr. Luxmoor, of London, as early as 1809, long before Civiale's time. See Gouley on Diseases of the Urinary Organs, page 16.

What then should be done? The stricture should by all means be divided. In six hundred recorded operations of internal urethrotomy he had never once had any disastrous effects result, but, on the other hand, there had been entire disappearance of the stricture in every case where a complete cutting had been made. Within the coming month he expected to report fifty cases of perfect cure, in which all the patients had been finally examined at considerable periods after the operation.

Dr. Keyes thought it was possible to talk to any extent on this subject, which had always been a notorious one for discussion among New York surgeons. He had always considered it the first axiom in urethral surgery to let everything alone until symptoms should arise demanding attention; but if Dr. Otis's idea were to be followed out it would be necessary to rifle every male urethra in the community, and there would have to be a number of practitioners whose sole duty it would be to examine people for strictures. In his own experience gradual dilatation by means of steel instruments had proved the best method of treatment of stricture; and in any case the patient was let alone whenever he was free from symptoms, without reference to the exact size to which his urethra might have been brought. It should be our aim, he thought, to treat disease in general in such a way as to get rid of the trouble occasioned by it; but if in any case there were pathological conditions present, such for instance as hæmorrhoids or enlarged prostate, without producing any symptoms, he would not consider it good practice to interfere.

There could be no question that gradual dilatation was in the long run very effective, and if after it had been employed there were no symptoms the patient was certainly practically well. After the treatment had been discontinued he could pass the sound himself from time to time, and with a little practice could do it a great deal better than the most skillful surgeon. As adjuncts (and not substitutes) in certain cases he was in the habit of employing internal urethrotomy when the stricture was situated in the pendulous portion of the urethra, and divulsion when in the deep part. Both operations were good in their way, but cutting was better in the anterior part of the canal on account of the efficient manner in which hæmorrhage could be controlled there; while on account of the difficulty of controlling this in the posterior portions divulsion was preferable in this situation. Neither of them were of universal application. He had had but one death from divulsion, but still he was convinced that gradual dilatation was by far the safest of all, and the safety of such an operation was certainly a matter of vast importance.

In regard to the incision of the meatus, Dr. Keyes remarked that he could not see any reason for cutting unless it were positively necessary in order to dilate the stricture sufficiently. If, when the calibre of the meatus had been reached in the sounds employed, the symptoms ceased, he would stop there; but if they did not then disappear he would enlarge the meatus. But however much the meatus were extended, and however freely the stricture itself were cut, he did not believe the normal character of the canal could be entirely restored. He had himself cut patients until the seat of stricture would admit a number 42 sound of the French scale, and yet a number of distinctly rubbed places could be detected with a number 40 bulb. In like manner he supposed that if the stricture had been enlarged to 52, a 50 bulb would have detected them. If

relief from symptoms were obtained, it was all the cure that we could reasonably desire; and it was a fact that there were some cases which did not get well, no matter how freely they might be cut.

At this point Dr. Gouley asked Dr. Otis if by the six hundred operations to which he had referred he meant six hundred distinct cases or six hundred strictures; to which the latter replied that there were six hundred strictures, and but four hundred cases, and that there had not been a single death among them.

Dr. Weir, the president of the association, was the next speaker. He commenced by quoting some statistics sent him by Dr. Mastin, of Mobile, who preferred dilatation as a rule. As most of the strictures, however, were in the anterior portion of the urethra, he employed urethrotomy a great deal. There had been ten deaths in one thousand cases, but in two hundred and ninety-one of these there was no death. Such statistics, Dr. Weir thought, did not afford us a fair opportunity of judging in regard to the mortality of operations. Strictures situated in the anterior part of the urethra were not, as a rule, very tight, and could be treated with the knife almost with impunity; but in regard to those in the deeper portions it still seemed to be an open question as to which method of treatment was really the safest and best. For his own part, however, he did not see why we should divide moderate strictures.

During his various terms of service at the New York, the Roosevelt, and St. Luke's hospitals he had operated in one hundred and fifty cases, with a mortality of fourteen, or nine per cent. He had performed internal urethrotomy fifty-one times, with a mortality of five per cent., and of these cases twenty-two admitted only a filiform bougie. Thirty-one of the strictures were situated at or near the bulbo-membranous junction, and the others in the anterior portion of the urethra. He thought it a matter of great importance in recording cases that the operator should always state definitely whether the stricture were in the deep or anterior portion. He had twenty-eight cases of external urethrotomy with six deaths, or a mortality of twenty-one and a half per cent.

Dr. Otis stated that in the greater proportion of his cases the stricture was situated within the first three inches from the meatus, and that he had met with a large number of instances in which deep strictures were supposed to be present, but really did not exist at all. Surgeons were often deceived by the effect produced by contraction in the anterior portion, but when this part was well cleared the supposed deep-seated stricture was also found to disappear. Only a few days before he had seen a case in which he at first thought there was a filiform stricture in the deep part of the urethra, but when an existing anterior stricture was removed a number 35 sound passed into the bladder without the slightest difficulty. There had been simply a spasmodic constriction caused by the anterior stricture. He was himself entirely opposed to deep urethrotomy unless it were absolutely necessary, and would never think of attempting it until all trouble had been removed in the anterior portion of the canal.

The concluding remarks were made by Dr. Gross. After corroborating Dr. Otis's views upon the last point, he spoke of the relative mortality of operations in private and hospital practice, and stated that in his experience this was

much greater in the latter than in the former. In the Philadelphia Hospital he had once lost three out of twelve cases, all of the three men being affected with granular contracted kidney; while in private practice he had had seventy-five operations by divulsion or internal urethrotomy without a single death. He then went on to state that he still held that no man has ever *cured* a case of stricture by gradual dilatation. "Let any surgeon you please treat a case for ten weeks or ten years in this way, and I will venture to say that at the end of that time the stricture will still be found the same as before, if the man be examined by competent judges." As Dr. Keyes had remarked, there might be no symptoms, but the stricture would still be there. He therefore considered gradual dilatation entirely useless as a method of cure. It might make the patient comfortable, but it did not get rid of the cicatricial tissue always present. If the normal anatomy of the urethra were studied, it would be proved that there were longitudinal folds in it, made up of reduplications of the mucous membrane. These were seen when the canal was relaxed, but when it was distended with urine these folds disappeared, on account of the stretching of the parts. It would furthermore be found that these rugæ depended on elastic fibres underneath the mucous membrane. In stricture, he continued, inflammatory action always precedes the constriction, and, as a consequence of this, the longitudinal folds become glued together, so that the urethra can no longer be distended as it ought to be. Now, why do we try to attempt a permanent cure? In order that the canal may again be distended to its natural size. By urethrotomy we "put in a splice," and cause the formation of new rugæ; and that splice can never be put in by dilatation, though we can perhaps do it by divulsion.

Divulsion is very good as a temporary expedient, as in the case of a laboring man, for instance, on account of the saving of time. But afterward, when a favorable opportunity occurs, we should always complete the business by means of urethrotomy. I do not hesitate to say that the cutting operation is as safe in the deeper parts of the urethra as anywhere else; but when I make this statement I do not mean the operation as performed with such instruments as that of Dr. Otis, which is really a divulsor as well as a urethrotome. As a consequence, more hæmorrhage is excited by it than there ought to be. If the kidneys and other portions of the urinary apparatus are in a healthy condition, urethrotomy with a proper instrument is as safe an operation as the simple passage of a catheter. In the Philadelphia Hospital I have met with two cases in which catheterization was followed by death, the kidneys being diseased, and uræmia setting in.

PROCEEDINGS OF THE CONNECTICUT MEDICAL SOCIETY.

EIGHTY-SEVENTH ANNUAL MEETING.

THE society met for business at three P. M., Wednesday, May 22d, at New Haven, with an unusually large attendance of Fellows. The society is made up of a union of the eight county societies, and the business of the state society is transacted by five Fellows elected from each county and the officers of the society. The presidents of the county societies are *ex officio* vice presidents of the state society.

According to custom the president, Dr. R. Hubbard, of Bridgeport, gave a brief address of welcome, reviewing the history of the year and the work of the society in the past, outlining the principal business before the convention, and congratulated the society on the establishment of a State Board of Health.

Several amendments to the by-laws were disposed of, and the following resolution adopted unanimously and referred for final action as a by-law next year : —

" Each county association shall have power to examine, discipline, or expel any member professing or avowing to practice allopathy, homœopathy, hydropathy, or according to any exclusive system or dogma."

Dr. S. G. Hubbard, of New Haven, read a memorial from the New Haven County Medical Association entitled *The Profession and its Relation to the Public*. The object of the paper was the guarding against the admission of unqualified men to practice in this State, and the securing of suitable legislation to obtain the desired result. The memorial, after setting forth previous steps taken in this direction, and other matters in point, concluded with the following resolutions : —

Whereas, There is nothing in the statute laws of Connecticut which prohibits any individual from publicly assuming the title and functions of a physician, without the least knowledge of medical science ; and

Whereas, The perfect freedom thus guaranteed to quacks and itinerants from other States to practice their frauds in this State without legal impediment offers special inducements to this class of pretenders to select this State for their field of operations, greatly to the damage of the lives and property of the citizens ; therefore

Resolved, That in the opinion of this association the best interests of the people and the claims of public policy alike require certain legal restrictions, at least to the extent of requiring that hereafter every practitioner of medicine shall be a graduate of a regularly chartered existing medical college, or shall have been licensed to practice by some one of the medical societies chartered by this State, and duly authorized to grant licenses.

Resolved, That these resolutions be signed by the officers of the association, and be transmitted, with the foregoing memorial, to the president and Fellows of the Connecticut Medical Society at their annual meeting ; and that the Fellows from this county are hereby respectfully requested to use their influence to secure appropriate action thereon, to the effect that the subject may be brought by a suitable committee before the next General Assembly in a well-considered and practicable bill for a public act regulating the practice of medicine in this State.

The paper was referred to a special committee, who reported in favor of a committee, to be appointed from each county, to draft a bill and submit the same to the medical organizations in the State to secure their coöperation, and report to the next convention.

The subject of granting licenses to practice medicine was then brought up, with direct reference to a recent case where the power that had not been exercised for many years was revived. It was claimed that undue influence had been exerted by Dr. Willard Parker, of New York, in writing to the exam-

ining board, requesting their favorable action; and that the candidate, failing to pass a satisfactory examination, was nevertheless licensed. The power to grant licenses still belongs to the state society, though seldom exercised, and a committee was appointed to endeavor to secure an act rendering all licensing illegal hereafter, or requiring the same qualifications as for a degree. The power of granting degrees in this State is shared by the Connecticut Medical Society and the Yale Medical School, and is embodied in a regulation of the charter. The following resolution was passed, which may also embrace other changes, and in all probability will include the requirement of a preliminary examination before entering the medical school at Yale, which has already advanced as far in efforts to elevate the standard of medical education as charter limitations will allow:—

Resolved, That the Connecticut Medical Society be requested to appoint a committee of three to confer with a similar committee representing the medical college, to consider the propriety of making some changes in the charter of the Medical Institution of Yale College, with authority to coöperate with said committee in securing from the legislature such alterations as may be mutually agreed upon.

The president appointed as members of the committee C. W. Chamberlain, M. D., Luther H. Wood, M. D., and H. P. Stearns, M. D.

The officers of the society are nominated by a committee composed of one from each county society, and chosen by the Fellows present from each county.

The convention then proceeded to the election of officers and committees for the year ensuing, upon report made by the nominating committee, the result being as follows: President, C. M. Carleton, Norwich; vice-president, A. R. Goodrich, Vernon; Treasurer, F. D. Edgerton, Middletown; Secretary, C. W. Chamberlain, Hartford.

Committee on matters of professional interest, W. A. M. Wainwright, Hartford; H. W. Buell, Litchfield; and A. Woodward, of Franklin.

To fill vacancies in the examining committee, M. Storrs, of Hartford, and J. Witter, of Putnam.

Committee to nominate professors for the medical institution of Yale College, Samuel Lynes, Norwalk, and L. N. Beardsley.

Committee to nominate physicians for the Retreat for the Insane, L. Holbrook, of Thompson, and H. M. Knight, of Lakeville.

The treasurer's report showed a gain of one hundred and forty dollars in the treasury in excess of the balance of last year, and indicated an efficient management of the financial department.

After transacting the usual routine business, the society adjourned until eight P. M., for the report of the committee on county resolves, to which had been referred a case of discipline.

Evening session. The society assembled at eight P. M., the vice-president, Dr. C. M. Carleton, in the chair.

The subject of an act regulating the practice of medicine was discussed fully. There was a pretty decided agreement as to the desirability of such a measure, but considerable difference as to methods. In order that the bill might embody the most effective provisions, and those found most practical in

other States, it was finally decided to request the committee to report a bill to the next convention, which should previously be sent to each county society, and to the individual members for suggestion, and to gain their aid in securing legislative action.

The committee on county resolves presented a majority and minority report on the case of Dr. M. B. Pardee, of Norwalk, expelled from the county society for consulting with his wife, a homœopathic physician. The grounds on which the majority report was based were that the charges were not proven, as there were no affidavits presented not met by as strong counter-affidavits from the same or connected parties, while the *prima facie* evidence, taken in connection with the other, rendered acquittal impossible. The case was therefore referred back to the county society. The minority report recommended expulsion.

The case was thoroughly presented in all its aspects, and after a long debate lasting until midnight the majority report was sustained.

Thursday, May 23d. The society met at nine A. M. The secretary reported the names of thirty-one new members and sixteen deaths, a very unusually large mortality. Ten were over sixty years old, the oldest eighty-seven, the youngest twenty-nine. The deaths of three honorary members were reported,—Dr. Nathan R. Smith, Baltimore, Dr. Hiram Corliss, New York, and Dr. Thomas Sanborn, of New Hampshire. The society now numbers 395 against 384 last year, and is steadily gaining each year.

The president, Dr. R. Hubbard, of Bridgeport, read his annual report on The Mutual Relations of the Public and the Regular Medical Profession. He began by speaking of the strenuous efforts made to discover some complete science of medicine, or universal law of cure, by which to determine all measures to be adopted for the protection of human life and health, and was compelled to admit that, notwithstanding the great advancement made, the profession must still find its way in many directions by the faint light of experience, or of rational empiricism. He spoke of the duty of all regular practitioners in the profession to stand between the public and all sorts of medical pretenders and impostors. Hydropathy, Thompsonianism, botanicism, and other exclusive systems were spoken of as one-sided theories, worthy of only passing notice. Homœopathy, he said, had long held an attitude to the public of hypocrisy, and towards the regular profession and their principles and practice of unmitigated, persistent denunciation. At first homœopaths followed the theories of the Hahnemannian system, but "homœopathy, to-day, tried by the criterion of its standard literature, does not exist; its votaries have long since, without a visible struggle, abandoned one of its only two distinctive dogmas, namely, that of the potency of infinitesimal doses of articles of the *materia medica*, and have made such rapid progress in the administration of the 'raw material' that it requires a practitioner of no ordinary courage in the 'old school' to emulate their heroism." "We believe the homœopathic system to be false in theory and pernicious in practice, and therefore that we have no moral right to pursue such a course as will indicate to the public that it is worthy of confidence. This is not stronger than the language of Hahnemann

himself." The eclectic system, the second and last competitor for public favor, is an outgrowth or culmination of Thompsonianism and the botanic system. The speaker said that this, like all exclusive systems of medicine, offers no new principles that will bear critical analysis, but is marked rather by an arbitrary selection of certain articles of the *materia medica*, giving preference, without any good reason, to those derived from the organic kingdom, and ruling out specially the several compounds and preparations of mercury, arsenic, antimony, and lead. This was characterized as absurd, as these articles had been proved to be entitled to rank as remedies by the experience and observation of those who have tried them. He closed by speaking of the many valuable inventions and improvements of late years.

Dr. A. M. Shew, of the Middletown Insane Asylum, presented a dissertation on *The Relations of Insanity to Law*. He treated the subject in all its bearings in a masterly and exhaustive manner, and presented many practical points which will doubtless be brought up for legislative action in the near future.

The *Ætiology and Treatment of Puerperal Convulsions* was discussed in an essay by Dr. L. S. Paddock, embodying a clear *résumé* of all that is known on the subject.

The report of the Committee on Matters of Professional Interest in the State, read by Dr. Wainwright, of Hartford, touched, among other things, upon typhoid fever. Concerning the cause of typhoid fever there are two distinct theories: (1.) The theory that the poison of the fever originates in the decomposition of organic substances. (2.) The theory that the fever poison is propagated continuously, and never originates *de novo*. This latter belief originated with Budd, and is followed most firmly by Liebermeister, who was quoted by the report at some length. The committee looked into the two theories, and obtained statistics that showed that in Great Britain there are annually 140,000 cases of typhoid fever (15,000 of them fatal), and in the United States 37,605 persons (census of 1870) die of this disease. In conclusion, the report advises careful study, upon the part of the members, of this disease in all its bearings, and of these there is none of greater importance than its *ætiology*.

The following are the questions sent out by the committee, the object of 5 and 6 being to stimulate thought and investigation: (1.) What diseases have prevailed in your locality during the past year? (2.) Has there been any serious epidemic? (3.) To what extent has typhoid fever prevailed? (4.) Have you observed any change in the type of typhoid fever during the past ten years? (Is the disease as frequent, severe, or fatal as formerly?) (5.) In what percentage of cases of zymotic diseases have you been able to trace the exciting cause to bad sewerage, drainage, etc.? (6.) Have you ever known a case of typhoid or scarlet fever, or diphtheria, to arise spontaneously (every possible source of transmission from some previous case having been eliminated)? (7.) To what extent have diseases of malarial origin increased in your neighborhood during the past year? (8.) In vaccination, do you use bovine or humanized virus? (9.) What has been your percentage of successful vaccinations during the past year? (10.) Have you ever observed any

serious trouble to arise from vaccination? (State cases and kind of virus used.)

Dr. J. R. Bronson, of Massachusetts, was present as a delegate from the medical society of that State, and addressed the society in a very happy manner, presenting the greetings of the Massachusetts Medical Society and expressing the desire for a closer relationship between the societies.

Dr. R. F. Weir, of New York, and Dr. E. E. Holt, of Maine, presented the greetings of their respective societies with brief speeches, and urged the desirability of the Connecticut society sending representatives to the meetings of sister societies.

Dr. Russell as delegate to Pennsylvania, Dr. Hills to Rhode Island, and Dr. Chamberlain to Massachusetts reported an account of their respective visits. Among other things, the greater activity and interest of the Massachusetts society in public affairs were noted, and the social features so prominent in the Rhode Island society, as well as the large attendance and interest in the meetings, which are held quarterly.

Dr. G. P. Davis gave a very interesting demonstration of the methods used in antiseptic surgery, with exhibition of the apparatus and the details by applying the dressings, etc., under the spray from an atomizer devised by Dr. Weir, of New York. He gave a brief outline of the theories upon which the methods are based and the results obtained.

Dr. Bronson spoke of the results in the Massachusetts General Hospital, and Dr. Weir made extended remarks upon the general methods and obstacles. He stated that although thymol was less objectionable to handle than carbolic acid, it was not as effective, a larger percentage of failures occurring under its use in his hands.

Dr. S. H. Chapman presented a paper discussing the treatment of throat and ear disease, following the Vienna school mainly in his methods, and advocating the use of as strong solutions in the ear as in the throat, illustrating his theories with cases.

Dr. Barbour reported a series of four cases of thoracentesis in empyema, with recovery, rather an unusually favorable percentage. Two were aspirated, and in two free drainage was established.

The remainder of the session was occupied with the reading of voluntary papers, principally of unusual cases: Hemiplegia Alternans, Dr. W. C. Burke; Spinal Meningitis, Dr. C. M. Carleton; Extra-Uterine Pregnancy, Dr. E. F. Coates; Cardiac Thrombosis, Dr. I. W. Lyon, etc., etc. The session closed with a dinner at the New Haven House, which was a very pleasant affair.

PROCEEDINGS OF THE GYNÆCOLOGICAL SOCIETY OF BOSTON.

HENRY M. FIELD, M. D., SECRETARY.

THE ninety-first regular meeting of the Gynæcological Society of Boston was held, according to announcement in the JOURNAL, at the Evans House, on the first Thursday in May, at three o'clock P. M. After the transaction of preliminary business, the doors were opened to such of the profession as had

responded to the general invitation to attend. Among others present were Drs. Garratt, Gilman, Kimball, Marcy, and Norris of Cambridgeport, Jones of Newton, and Wingate of Wellesley.

DR. CUTTER, active member of the society, proceeded to give a digest of Fifty Cases of Uterine Fibroids treated by Electrolysis, conjointly by himself and Dr. Kimball. It is impossible to give any sufficient report of this interesting and striking paper, which, from the mass of material and the limited time, could be presented only in the most concise and summary way, but by previous arrangement with the author and the society an adequate review will appear in the *American Journal of Medical Sciences* in July.

The uterine fibroid had proved intractable under other methods of medical and surgical treatment, but results by electrolysis had exceeded expectation. Two ladies, who had been cured by this method, had kindly consented to be present, and were introduced to the society, — their cases being given in detail.

Upon invitation of the chair DR. GARRATT followed with brief remarks. The question of interest is, Does the electric fluid pass through the tissues? He formerly believed that it did not; he now knows that it does. He had given a great deal of study to this question; an ordinary galvanometer will not solve the problem, but his own more perfected instrument had done so. The old idea that the human body resists the passage of the electric fluid is false; it is a better conductor than water; indeed, one of the best of conductors. He did not understand how the process was set up by which the tumor was removed, but that it accomplishes such removal there can be no doubt. Dr. Garratt farther observed that when Dr. Cutter first called on him some years ago with the project, which had been so well developed and so completely justified by the paper just presented, he was skeptical; very willing that the experiment should be made, but he had no faith in any practical results. He was glad to testify that Dr. Cutter was right, and that he had gone farther in this department than he had himself.

DR. WARNER asked whether the electric fluid would as readily pass through dead as living flesh.

DR. GARRATT replied: No; experiments on the cadaver were not conclusive.

THE OBLIGATION OF THE MASSACHUSETTS MEDICAL SOCIETY TO FEMALE PHYSICIANS.

AN article on another page takes ground on this subject so opposed to our own views that we feel called upon not to let it pass without comment. The writer truly says that the society is intended as a body to regulate the standard of education in the State, "to fix a minimum of attainments" considered necessary for a respectable practitioner. In addition to this, the prime function of the society, there are also the scientific, ethical, and social features, which, under the wise management of past years, have made this body one of the most harmonious, prominent, and highly respected of its class in the country.

Does such a body as this sacrifice its reputation for liberality and progressive-

ness by declining to receive women into its ranks? This is a question answered by Dr. Edes in the affirmative, arguing, as we think, from a somewhat ideal point of view, although not granting that privilege to the society. Taking a matter-of-fact view of the situation, a position which it behooves every member to assume in considering so radical a change, we may well ask, in the first place, why a medical organization like ours should be held up to be stigmatized as a brutal example of selfishness in excluding women. It is claimed that as a scientific body we have no right to make distinctions of sex; but there are innumerable bodies of the kind in this city and all over the country, of the highest standing, which do not contemplate any such change. Whether we look at the question from a business or an educational point of view, we still find most important branches of industry and many of our oldest seats of learning, sources of national prosperity, preserving a most conservative attitude; indeed, the very government itself does not give the slightest control to a class which furnishes a large portion of its revenues. But taking example or precedent for what they are worth, if we look the motives underlying this movement squarely in the face we shall find something akin to that peculiar restless spirit which impels Americans to seek a higher walk in life than that for which by their surroundings or education they have been fitted. In the miscellaneous collection of individuals whom we are to receive as applicants there are undoubtedly a few well-educated women fitted for the duties they have undertaken. Not only these will be candidates, but others who have picked up an education which, rated even by the prevalent low standard, would be considered meagre, and who, although they might prove excellent midwives or nurses, would hardly be considered desirable colleagues either from a scientific or social point of view. To give, then, somewhat indiscriminately to these persons the privileges of membership, as, under pressure of public sentiment, we should be likely to do, seems to us to foster that unhealthy ambition which it should be our duty as an educational and scientific body of good standing to discourage. Regarded in this light the functions of our society require us carefully to avoid confusing education and science with questions of sentiment and taste. Though, taken from the latter point of view, we think a strong conservative element would be found which looks with disapprobation upon the fashion in Massachusetts to try all sorts of quixotic experiments, and who regret to see women unsex themselves by breaking through barriers hitherto considered sacred, when opportunities for less sensational but more useful careers abound. With all the good will in the world, however, towards female physicians as a class, we may still hesitate to take a step which the founders of the society never contemplated, and which may endanger the very objects they and their successors have always had in view. By leaving the woman question to take care of itself, to grow up or fail on its own merits, to demonstrate the capability of women to study, to teach, to practice, to organize themselves into an influential and respectable body without adventitious aids, the society would, it seems to us, impose upon the reformers no severer conditions than the world usually exacts, and such as would in the end be most advantageous for their future welfare should they succeed.

MEDICAL NOTES.

—The annual meeting of the Massachusetts Medical Society will be held on Tuesday and Wednesday next at the rooms of the Lowell Institute. We have already given a list of the papers to be read. The special features of the meeting will be the proceedings of the Massachusetts Medico-Legal Society, to which Tuesday afternoon will be devoted; the annual discourse by Dr. Francis Minot, an abstract of which will be given in the *JOURNAL* of next week; and the dinners in the Music Hall, which will be presided over by Dr. Peter Pineo, of Hyannis, under whose able management the entertainment promises to be an unusually agreeable one. We understand that Dr. S. D. Gross, of Philadelphia, will be present, and also Dr. Woodworth, of Washington.

—The Roxbury Dispensary, which has been carried on for many years as a separate organization or under the charge of the Roxbury Charitable Society, was given up June 1st on account of lack of funds and the great expense attending it. There is now no provision for the sick poor of the Highland District except at the City Hospital.

—It has been wickedly remarked that a woman who practices medicine commits two faults: she increases the number of doctors and diminishes the number of women.

—A Paris correspondent of the *Lancet* writes that three chairs devoted to specialties have, "with considerable diffidence and hesitation on the part of the professors," been established in the Medical School of Paris. He also says that in the Exhibition is a series of "plated human brains" prepared by the galvano-plastic method, by Dr. Oré, of Bordeaux. Externally the brains present the hard, brilliant surface of a metal, the inner surface having the consistency of mastic and being quite unalterable.

—Placenta prævia with excessive flooding, use of tampon, expulsion at fourth month of a dead and retention to full term of a living twin are points of interest in a case reported by the *American Practitioner*.

—Dr. Oertmann suggests a "new method" for determining the temperature of patients, namely, to have the urine directed in a strong current against the bulb of the thermometer. Seven seconds of this procedure will suffice. This method was proposed ten years ago by the late Professor Dickson, of Philadelphia.

—Dr. Dietl has been made professor of experimental pathology at Innsbruck.

—In the London *Lancet* we find these sensible and seasonable remarks in reference to training for boat-races: "Every year we hear of improvements in the method of training pursued, and a discarding of many absurd restrictions and antiquated ideas. There is one notion, however, that still holds firm possession of the rowing-man's mind, and that is the doctrine of *internal fat*. The shortness of breath he experiences at the commencement of training, he will admit, is caused by embarrassment of the respiration and circulation before the system accommodates itself to the work thrown upon it by the increased muscular exertion. But when this accommodation is effected, how is it, he argues, that he occasionally finds his wind fail him over the course unless

the view of internal fat be adopted? The supposition, however, of a deposit of fat occurring to any extent at the age at which the majority of men go into training is untenable, and the suddenness with which the respiratory trouble appears and disappears is against the time-honored view. The rational explanation of these occasional attacks of "short wind" lies in a distended condition of the bowels, either with undigested food, or flatulence, or accumulated feces; for constipation is one of the rowing-man's chief difficulties. The dyspeptic trouble may be due to an exhausted condition of the body, and may be a sign that the muscular exertion is too severe; but generally it is due to taking a heavy meal too soon after hard exercise. The presence of undigested food, as well as accumulated feces, leads to flatulence, by which the distended bowels become still more distended. And it is easy to understand that whatever distends the bowels encroaches upon the respiratory cavity, and embarrasses the breathing. Instead, therefore, of attempting to diminish an imaginary deposit of fat by increased exertion or restriction of certain articles of diet supposed to favor its formation, he should combat "this wind in the wrong place" by a change for a day or so to a lighter and more digestible diet, — from beef and mutton to poultry, — and clear the intestinal canal at the earliest opportunity of the undigested residue and fecal matter with a dose of Fredrickshall or Pullna water."

— Rhode Island has organized a State Board of Health with Hamlet (Dr. Snow) left out. The *Record* thinks this is not a very strong argument in favor of the good intentions of the framers of the law.

— Oxalate of cerium is recommended in chronic cough. In five-grain doses it is said to give comfort to the lungs and relieve the cough for twenty-four hours after each dose.

COMPULSORY STATE EXAMINATIONS IN GREAT BRITAIN.

MR. EDITOR, — The legislatures of Great Britain and of some of the United States have introduced within the last few weeks bills for the better regulation of medical examination and registration. It may therefore be of interest to your readers if I give them an account of the present position of the medical profession in Great Britain, and of the means by which an entrance into the profession can be effected.

There are in the United Kingdom of Great Britain and Ireland nineteen bodies which have the right to examine students and to grant them qualifications entitling them to be registered as legally-qualified medical practitioners. Of these nineteen bodies ten are universities which confer degrees in medicine and surgery (bachelor of medicine, doctor of medicine, or master in surgery), the other nine bodies being colleges or societies which grant a diploma or simply a license to practice in medicine or surgery, or both. Many of these corporations have more than one variety of diploma at their disposal, and hence there has arisen a great multiplicity of medical titles and qualifications, any one of which is sufficient to enable its holder to practice.

This multiplication of licensing bodies would matter little if the standard of examination were the same in all, or at any rate if it were quite certain that none of the examinations were below a well-defined minimum of severity;

but, unfortunately, this is by no means the case, for there is a tendency among some of the minor corporations to bid for students by holding out the inducement of an easy examination, and hence a competition of a very unhealthy nature is apt to be set up. In this way it has arisen that the holder of a license from a college in London — say the College of Physicians — will have had to pass an examination of a very different order from that which obtains the diploma of a college of the same name in Scotland or Ireland, and the degree of M. D. varies very much in value according to the status of the university which has granted it. It is needless to say that great confusion has arisen in the minds of the uninitiated as to the relative value of the different diplomas, and so far as the public is concerned a student gains little by putting himself to the trouble and expense of obtaining a first-rate degree.

It may be asked, How has it arisen that there is such a multiplicity of licensing bodies, and how have the existing corporations obtained their legal recognition to grant diplomas and degrees? This is to be traced back to the days when centralization had scarcely begun to make itself felt, and when each small district contained within itself all the machinery necessary for the conduct of its own affairs. Each of the several kingdoms which together make up the United Kingdom contained its own metropolis, which formed the political and intellectual centre of its own district. In each metropolis a College of Physicians and a College of Surgeons was founded; and just as Ireland and Scotland retained many of their political institutions independent of those of England long after the union between the countries, so they have kept their own Royal Colleges of Physicians and Surgeons, from which Scotch and Irish students respectively obtain their diplomas. Each metropolis, moreover, has its own university, and in addition other universities have been founded in various districts, many of them centuries ago, and in all of these medicine originally constituted one of the faculties, and each of them has retained its ancient right to grant medical degrees. The power thus attaching to these various bodies was originally obtained by virtue of a separate charter granted by the crown to each of them, and it was not till 1858 that the first step was made towards binding them together under one controlling head. In that year a medical act was passed through Parliament, which defined the rights of the existing bodies and established the necessity of a registration by all practitioners of their degrees or diplomas in a general register to be kept for the purpose, without which they would not be legally qualified to practice. In the year 1862 the bond thus instituted was further strengthened by the creation of a body known as the General Medical Council, which was intended to take the position of a medical parliament; to watch over the general welfare of the profession, to initiate legislative reforms, and to make itself responsible for the proper performance of their functions by the various examining boards in the country. It was to consist of twenty-four members, seventeen of whom were to be nominated by the nineteen universities and corporations already mentioned (some of the smaller bodies uniting to send a joint representative), the remainder being nominated by the crown. Hence the General Medical Council may be looked upon as a representative body for the various examining boards, even though it may not be so of the profession taken as a whole; and these boards

yielded up to it the right to grant the legal license to practice, the register being henceforth kept by the General Medical Council. But this latter body did not itself undertake to examine students, and hence it did not really interfere with the vested interests of the universities and colleges, but granted its license only to those individuals who had obtained a degree or diploma from one of them. In addition to this the Council has the right to inquire at any time into the courses of study and examinations to be gone through to obtain the diplomas of any of these bodies, and if it finds them not to be satisfactory it can interfere to get the standard raised; or on its recommendation the crown can suspend the charter of the delinquent body. In this way some guarantee is afforded that a definite minimum of knowledge will be established as a basis for medical examination, and the possibility is diminished of any one of the bodies seeking to attract students by lowering its standard unreasonably. The Council meets once a year, its session lasting about a week, and it is during that time that medical reforms are discussed and set on foot. Theoretically the working of the General Medical Council should be perfect, but in practice it is far otherwise, especially so far as examinations are concerned. In reality it has scarcely perceptibly altered the character of these. The standards vary as widely as before; the minimum amount of knowledge required by some of the corporations is allowed in all quarters to be too low; students are every day becoming legal practitioners with a very inadequate knowledge of their profession, whilst the public are as far as ever from being able to assure themselves that the medical practitioners on whom they may have to rely have been subjected to sufficient tests of knowledge. This unsatisfactory position of affairs has long been recognized, not only by the medical public and by the more stringent corporations, but by the Medical Council itself, and for several years past strenuous efforts have been made to carry into effect a scheme which has been drawn up to meet the difficulty. This scheme was to establish a state examination, which every student must pass before he could become legally qualified, which would be the same for all, and which would therefore at one stroke introduce uniformity where there is now so much discrepancy. The great difficulty in the way of this much-needed reform has been to obtain the consent of the various bodies to a plan which in the case of several of them must practically mean extinction. Parliament might, of course, have passed a compulsory act, instituting the state examination and compelling the bodies to give up their rights; but it was felt that it would be advisable to avoid so sweeping a step if possible, and to adopt the slower but more peaceable means of obtaining the desired end by getting the bodies to unite together of their own free will to establish a conjoined examination board which should consist of representatives from all the universities and other corporations, to raise this board to the dignity of an institution of the state, and to compel all students to pass through this one portal before they could be placed upon the register. The various bodies were still to retain their independence in other respects, and could grant degrees or diplomas to students; they could establish their own standards of proficiency, and, in fact, were to remain as before, except that their diplomas would not of themselves be sufficient to entitle the holders to registration, but would be regarded

merely as honorary distinctions. It was, however, found extremely difficult to obtain any unity of action on the part of the bodies concerned. Those of them whose standard was already very high, and whose degrees were accordingly already greatly sought after by the more able students, were not likely to be much interfered with, for it would be impossible to set the compulsory standard at the pitch of severity which would really test the better class of men, and hence these would still aim at distinction by adding to their state diploma that of one of the more stringent examining boards. There was then but little difficulty in obtaining the coöperation of such as these, and even certain bodies whose diploma would be practically replaced by that of the conjoined board — notably the College of Surgeons of England, which has hitherto constituted the almost universal portal for England — were sufficiently magnanimous to make the necessary sacrifice and to join in the scheme. The Scotch and Irish boards were, however, for the most part absolutely opposed to the measure. It is in these countries especially that the lowness of the standard of examination has been complained of, and it was at them that the present agitation was more particularly aimed. These bodies resisted to the utmost, and it soon became evident that without the use of compulsion no conjoined scheme would have the least chance of success so far as those two countries were concerned.

This, then, was the position in which things stood when the government took the matter up with a view to a final settlement of the difficulty. The English boards had at last agreed to a scheme of conjoined examination; the Scotch and Irish boards were almost unanimously in favor of the *status quo*. The most important medical papers called aloud for reform, and there is no doubt that they represented the general feeling of the medical profession, — at any rate in England. The government bill was introduced a few weeks ago, but gave satisfaction to no one. The question of an examination board which should constitute the sole portal into the profession is left by the bill in just the same position as it has hitherto been, for no compulsory clause is introduced, and all that the bill does is to give leave to any two or more bodies to conjoin if they think fit. This permission is of course perfectly inadequate, because of what use is it for all the English corporations to unite together to form an examining board whose standard shall be higher than the average standard has been up to the present time, if the Scotch and Irish bodies are at liberty to retain all their ancient privileged bodies who can still grant licenses to students who seek the easiest entrance into the profession, and in this way render the effort of the English boards altogether nugatory? The weakness of the government measure is so obvious, and it is looked upon with so much dissatisfaction by the majority of medical men, that its rejection is almost certain, and strenuous efforts are being made to obtain a compulsory bill which shall compel the refractory boards to make the necessary sacrifice of their private aims for the public good. We shall probably have to wait a year or two for this highly necessary step, but anything short of it would be useless, and there can be little doubt that the substitution for the present chaotic condition of things of the one compulsory state examination with its definite minimum standard is merely a question of time.

LONDON, April, 1878.

COMPARATIVE MORTALITY-RATES.

	Estimated Population, July 1, 1878.	Deaths during week ending May 25, 1878.	Annual Death-Rates per 1000 living.		
			For the Week.	For the Year 1877.	Mean for ten Years, '68-77.
New York.	1,093,171	439	20.88	23.42	28.71
Philadelphia.	876,118	256	15.19	18.80	21.54
Brooklyn.	549,438	187	17.69	21.51	25.50
Chicago.	460,000	108	12.21	17.83	22.39
Boston.	375,476	144	19.94	20.10	24.34
Providence.	100,000	26	13.52	18.81	19.20
Lowell.	55,798	21	19.57	19.09	22.50
Worcester.	54,937	18	17.05	14.07	22.30
Cambridge.	53,547	12	11.65	18.69	20.83
Fall River.	53,207			21.35	24.96
Lynn.	35,528	9	13.18	20.42	19.67
Springfield.	33,981	7	10.72	16.02	19.77
Salem.	27,140	6	11.49	20.38	21.15

ERRATUM.—In the JOURNAL, May 2, 1878, at the beginning of the second paragraph, page 573, for "six months" read "six years."

NORFOLK DISTRICT MEDICAL SOCIETY.—At the annual meeting of the society, May 14th, the following officers were elected: President, Dr. Robert Amory. Vice-President, Dr. William C. B. Fifield. Secretary and Librarian, Dr. Henry R. Stedman. Treasurer, Dr. Norman Call. Commissioner of Trials, Dr. T. H. Dearing. Reporter, Dr. James S. Greene. Nominating Councilor, Dr. C. Ellery Stedman. Committee of Supervision, Dr. John H. Richardson, Dr. John B. Moran. Councilors, Dr. R. T. Edes, Dr. J. H. Streeter, Dr. Joel Seaverns, Dr. A. H. Nichols, Dr. D. D. Gilbert, Dr. William P. Bolles, Dr. C. Ellery Stedman, Dr. D. S. Fogg, Dr. James Morison, Dr. A. D. Bacon, Dr. George W. Fay, Dr. Alexander R. Holmes, Dr. S. E. Stone, Dr. Joseph Stedman. Censors, Dr. Henry P. Bowditch, Dr. John W. Chase, Dr. O. F. Rogers, Dr. George K. Sabine, Dr. E. T. Williams.

THE next regular meeting of the Gynæcological Society of Boston—the ninety-first—will be held on the second Thursday of June, at three o'clock, P. M., at the Evans House.

The following papers may be expected:—

Dr. Field's paper on Charcot's Position respecting the Relation of the Ovary to Hysteria, etc., laid over from the last meeting.

Dr. A. C. Garratt has kindly consented to offer a contribution on the bearings of electricity upon certain points in gynæcology.

The profession are cordially invited to be present. Doors open after the transaction of society business.

HENRY M. FIELD, Secretary.

THE NEW HAMPSHIRE MEDICAL SOCIETY will hold its eighty-eighth annual meeting at Concord, June 18th and 19th. Officers: President, L. M. Knight, M. D., Franklin. Vice-President, A. F. Carr, M. D., Goffstown. Treasurer, Thomas Wheat, M. D., Manchester. Secretary, G. P. Conn, M. D., Concord. The following papers will be read:—

Modern Use of Stimulants in Disease. Has there been a Change in the Type of Disease? by T. J. W. Pray, M. D., Dover. Some of the Risks and Responsibilities connected with the Practice of Medicine and Surgery, by E. E. Graves, M. D., Boscawen. Concerning the Pauper Insane in New Hampshire, by J. P. Bancroft, M. D., Concord. Report on Surgery: (1.) Social Relations of Surgery; (2.) Surgery as a Science; (3.) Surgery as an Art; (4.) Summary, by William Child, M. D., Bath. Thoracocentesis, by G. M. Garland, M. D., Boston. On Carcinoma: Its Histology and Ætiology, by D. S. Adams, M. D., Manchester. On the Treatment of the Insane, by J. P. Brown, M. D.

The Society will adjourn for the anniversary dinner on Tuesday at one o'clock.

On Wednesday there will be reports of the district societies, delegates, and cases.